AMENDED IN SENATE MARCH 21, 2011

SENATE BILL No. 712

Introduced by Committee on Insurance (Senators Calderon (Chair), Anderson, Corbett, Correa, Gaines, Lowenthal, Price, and Wyland)

February 18, 2011

An act to amend Sections 790.03, 10234.86, 11093, 11788, 11790, 11874, and 12352 of, *and to add Section 923.6 to*, the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 712, as amended, Committee on Insurance. Insurance.

~~Existing~~

(1) Existing law creates the State Compensation Insurance Fund to be administered by its board of directors for the purpose of transacting workers' compensation insurance, and insurance against the expense of defending any suit for serious and willful misconduct, against an employer or his or her agent, and insurance to employees and other persons of the compensation fixed by the workers' compensation laws for employees and their dependents.

Existing law gives the Insurance Commissioner certain powers and duties regarding domestic fraternal benefit societies.

Existing law requires every title insurer to deposit $100,000 with the Insurance Commissioner or other designated official of its home state, as provided.

Existing law requires long-term care insurers to maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term

care insurance policies sold by the agent as a percent of the agent's total annual sales.

Existing law defines unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

This bill would make technical, nonsubstantive changes to those provisions.

(2) Existing law requires insurers transacting business in this state to at all times maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims for which the insurer may be liable, and to provide for the expense of adjustment or settlement of losses and claims.

This bill would require every admitted property and casualty insurer, unless otherwise exempted by the commissioner, to annually submit a Statement of Actuarial Opinion in accordance with the appropriate Property and Casualty Annual Statement Instructions of the National Association of Insurance Commissioners and specified supporting materials, as provided, and require the commissioner to adopt regulations related to those instructions. The bill would require that specified documents, materials, and other information provided to the commissioner in support of the opinion and any other material provided by the insurer to the commissioner in connection with the specified supporting documents be, among other things, confidential, privileged, and exempt from the requirements of the California Public Records Act.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 790.03 of the Insurance Code is amended to read:

790.03. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

(a) Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus

previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce the policyholder to lapse, forfeit, or surrender his or her insurance.

(b) Making or disseminating or causing to be made or disseminated before the public in this state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, any statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business, which is untrue, deceptive, or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive, or misleading.

(c) Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(d) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of an insurer with intent to deceive.

(e) Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer.

(f) (1) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity

or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

(2) This subdivision shall be interpreted, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, to require differentials based upon the sex of the individual insured or annuitant in the rates or dividends or benefits, or any combination thereof. This requirement is satisfied if those differentials are substantially supported by valid pertinent data segregated by sex, including, but not limited to, mortality data segregated by sex.

(3) However, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, but before the compliance date, in lieu of those differentials based on data segregated by sex, rates, or dividends or benefits, or any combination thereof, for ordinary life insurance or individual life annuity on a female life may be calculated as follows: (A) according to an age not less than three years nor more than six years younger than the actual age of the female insured or female annuitant, in the case of a contract of ordinary life insurance with a face value greater than five thousand dollars ($5,000) or a contract of individual life annuity; and (B) according to an age not more than six years younger than the actual age of the female insured, in the case of a contract of ordinary life insurance with a face value of five thousand dollars ($5,000) or less. “Compliance date” as used in this paragraph shall mean the date or dates established as the operative date or dates by future amendments to this code directing and authorizing life insurers to use a mortality table containing mortality data segregated by sex for the calculation of adjusted premiums and present values for nonforfeiture benefits and valuation reserves as specified in Sections 10163.1 and 10489.2 or successor sections.

(4) Notwithstanding the provisions of this subdivision, sex-based differentials in rates or dividends or benefits, or any combination thereof, shall not be required for (A) any contract of life insurance or life annuity issued pursuant to arrangements which may be considered terms, conditions, or privileges of employment as these terms are used in Title VII of the Civil Rights Act of 1964 (Public Law 88-352), as amended, and (B) tax sheltered annuities for employees of public schools or of tax exempt organizations described in Section 501(c)(3) of the Internal Revenue Code.

(g) Making or disseminating, or causing to be made or disseminated, before the public in this state, in any newspaper or other publication, or any other advertising device, or by public outcry or proclamation, or in any other manner or means whatever, whether directly or by implication, any statement that a named insurer, or named insurers, are members of the California Insurance Guarantee Association, or insured against insolvency as defined in Section 119.5. This subdivision shall not be interpreted to prohibit any activity of the California Insurance Guarantee Association or the commissioner authorized, directly or by implication, by Article 14.2 (commencing with Section 1063).

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

(i) Canceling or refusing to renew a policy in violation of Section 676.10.

SEC. 2. Section 923.6 is added to the Insurance Code, to read:

923.6. (a) Every admitted property and casualty insurer, unless otherwise exempted by the commissioner, shall annually submit the opinion of an Appointed Actuary entitled "Statement of

Actuarial Opinion." This opinion shall be filed in accordance with the appropriate Property and Casualty Annual Statement Instructions of the National Association of Insurance Commissioners (NAIC).

(1) For purposes of this section, the term, "property and casualty insurer" means any admitted insurer writing insurance as described in Section 102, 103, 105, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 119.5, 119.6, 120, 124, or 124.5.

(2) For purposes of this section, the following terms have the same meaning as used in the Property and Casualty Annual Statement Instructions of the NAIC:

(A) Actuarial Opinion.

(B) Actuarial Opinion Summary.

(C) Actuarial Report.

(D) Appointed Actuary.

(E) Statement of Actuarial Opinion.

(F) Property and Casualty Annual Statement Instructions.

(3) The commissioner shall adopt regulations related to the terms and conditions required by the Property and Casualty Annual Statement of Instructions of the NAIC.

(b) Every property and casualty insurer domiciled in this state that is required to submit a Statement of Actuarial Opinion shall annually submit an Actuarial Opinion Summary, written by the insurer's Appointed Actuary. This Actuarial Opinion Summary shall be filed in accordance with the appropriate Property and Casualty Annual Statement Instructions of the NAIC and shall be considered as a document supporting the Actuarial Opinion required in subdivision (a).

(c) An admitted insurer not domiciled in this state shall provide the Actuarial Opinion Summary upon request of the commissioner.

(d) An Actuarial Report and underlying workpapers as required by the appropriate Property and Casualty Annual Statement Instructions of the NAIC shall be prepared to support each Actuarial Opinion. If an insurer fails to provide either a supporting Actuarial Report or workpapers at the request of the commissioner, or if the commissioner determines that the supporting Actuarial Report or workpapers provided by the insurer are otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the

opinion and the basis for the opinion and prepare the supporting Actuarial Report or workpapers.

(e) Notwithstanding subdivision (d) of Section 6254 of the Government Code, subdivision (f), or any other provision of law, the Statement of Actuarial Opinion required by subdivision (a) shall be a public record and open to inspection.

(f) (1) Documents, materials, or other information in the possession or control of the commissioner that are considered an Actuarial Report, workpapers, or Actuarial Opinion Summary provided in support of the Statement of Actuarial Opinion, and any other material provided by the insurer to the commissioner in connection with the Actuarial Report, workpapers, or Actuarial Opinion Summary shall be confidential by law and privileged, shall not be made public by the commissioner or any other person and are exempt from the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any civil action brought by a private party.

(2) This subdivision shall not limit the commissioner's authority to release the documents, materials, and other information described in paragraph (1) to the American Academy of Actuaries' Actuarial Board for Counseling and Discipline (ABCD), or its successor, so long as those documents, materials, and other information are required for the purpose of professional disciplinary proceedings, and the ABCD establishes procedures satisfactory to the commissioner for preserving the confidentiality of the documents, nor shall this subdivision limit the commissioner's authority to use those documents, materials, or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(3) The commissioner may also exercise, with respect to the documents, materials, or other information described in paragraph (1), all the authority specified in subdivision (b) of Section 735.5, or any successor provision.

~~SEC. 2.~~

SEC. 3. Section 10234.86 of the Insurance Code is amended to read:

10234.86. (a) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of

the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(b) Every insurer shall report annually by June 30, the 10 percent of its agents in the state with the greatest percentage of lapses and replacements as measured by subdivision (a).

(c) Every insurer shall report annually by June 30, the number of lapsed policies as a percent of its total annual sales in the state, as a percent of its total number of policies in force in the state, and as a total number of each policy form in the state, as of the end of the preceding calendar year.

(d) Every insurer shall report annually by June 30, the number of replacement policies sold as a percent of its total annual sales in the state and as a percent of its total number of policies in force in the state as of the end of the preceding calendar year.

(e) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

~~SEC. 3.~~

SEC. 4. Section 11093 of the Insurance Code is amended to read:

11093. (a) If the commissioner finds that any of the conditions set forth in Section 11092 exist in respect to a domestic society, he or she shall, in an order to show cause, notify the society of his or her findings and wherein those conditions exist and shall set a date after a reasonable period of time on which it shall show cause why it should not be enjoined from carrying on any business until the overt act or violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

(b) If on such date the society does not present good and sufficient reason why it should not be so enjoined or why such action should not be commenced, the commissioner may present the facts relating thereto to the Attorney General who shall, if he or she deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

(c) The court shall thereupon notify the society of a hearing. If after a full hearing it appears that the society should be so enjoined

or liquidated or a receiver appointed, the court shall enter the necessary order.

~~SEC. 4.~~

SEC. 5. Section 11788 of the Insurance Code is amended to read:

11788. The State Treasurer shall be custodian of all securities belonging to the State Compensation Insurance Fund, except as otherwise provided in this chapter. He or she shall be liable on his or her official bond for the safe keeping thereof.

~~SEC. 5.~~

SEC. 6. Section 11790 of the Insurance Code is amended to read:

11790. All securities belonging to the fund shall be delivered to the State Treasurer and held by him or her until otherwise disposed of as provided in this chapter. Upon delivery of those securities into the custody of the State Treasurer, the securities shall be credited by the State Treasurer to the fund.

~~SEC. 6.~~

SEC. 7. Section 11874 of the Insurance Code is amended to read:

11874. On the effective date of this act the Controller shall draw his or her warrant in favor of the State Compensation Insurance Fund for the total amount of the funds in the custody of the Treasurer belonging to the State Compensation Insurance Fund, and the Treasurer shall pay that warrant.

~~SEC. 7.~~

SEC. 8. Section 12352 of the Insurance Code is amended to read:

12352. If the deposit is made in this state, it shall first be approved by the commissioner, who shall forthwith make a special deposit thereof in the State treasury, for the purpose specified in section 12350. The Treasurer shall give his or her receipt therefor, to the commissioner.

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